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ABSTRACT

The report presents an executive summary of the findings, conclusions, and recommendations of a comparative study to assess the services being provided to handicapped preschool children by Project Head Start and non-Head Start programs. This study is Phase I of a larger study of the process of mainstreaming handicapped children in Head Start Programs. Limited comparison of Head Start program services are made with those offered by other programs located in the same communities. Findings are presented in a question-and-answer format within each of the following areas of investigation: mainstreaming, staff characteristics, recruitment and outreach, screening services, diagnostic services, planning and curricula, monitoring activities, auxiliary service providers, and parent involvement. Four basic areas are recommended in which Head Start services to handicapped children can be improved: diagnostic services, program services (particularly with respect to individualized planning), program facilities and materials, and outreach procedures to seek out unserved handicapped children. (DLS)

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ED168236

# EVALUATION OF THE PROCESS OF MAINSTREAMING HANDICAPPED CHILDREN INTO PROJECT HEAD START

Phase I Executive Summary

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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## Abstract

Data were collected on the services provided to 269 handicapped children enrolled in Head Start programs during the 1976-77 program year. Children were selected from a nationally representative sample of 59 Head Start programs. Limited comparisons of Head Start program services were made with non-Head Start programs located in the same communities.

Results of the study indicate that Head Start programs have made substantial progress in their efforts to seek out and serve handicapped children. In particular, Head Start has achieved substantial success in its goal to serve handicapped children in a mainstreamed context. Relative to other preschool programs, Head Start is unique in its comprehensive approach to service delivery.

Study results indicated four basic areas in which the Administration for Children, Youth and Families can take positive action to further improve Head Start services to the handicapped. These four areas include: 1) the nature and quality of diagnostic services; 2) the nature and quality of program services, particularly with respect to individualized planning; 3) improvement and acquisition of program facilities and materials; and 4) the nature and quality of outreach procedures to seek out unserved handicapped children.

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# INTRODUCTION

## Background

This report is a summary of the findings, conclusions, and recommendations from the first year of a two-year study of handicapped children enrolled in Project Head Start. The study was funded by the Administration for Children, Youth and Families (ACYF) and was conducted under contract to Applied Management Sciences during the 1976-77 Head Start program year.

The purpose of the first-year study was to review and describe the services provided to handicapped children in Head Start.[1/] Data collected will assist ACYF program planners to improve the quality of Head Start services and to augment annual reports to the Congress concerning the status of the Head Start handicapped effort.

## Study Methodology

The first-year study was designed to compare services provided to handicapped children in Head Start programs with those offered in other preschool programs that were potential placement alternatives for Head Start enrollees. The study was also designed to collect child specific study information on a sample of handicapped children actually enrolled in Head Start programs. Child-specific data were not collected in the first-year study from children enrolled in the non-Head Start programs.

### *Head Start Program Sample*

The sample of Head Start programs was selected from the universe of approximately 1,600 full year grantees or delegate agencies funded

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1/ The second-year study is designed to assess the impact of Head Start services upon the development of handicapped children and is scheduled for completion in November, 1978.

as of September 30, 1976. Grantees were stratified on the basis of the following two variables:

- urban/rural location
- program enrollment size

Fifty-five programs were randomly selected in proportion to their joint representation within these strata. An additional five programs were then randomly selected from a roster of Indian and migrant programs, yielding a total initial sample of 60 Head Start programs. However, data were only collected from 59 programs because one program had not yet identified any handicapped children at the time data collection was undertaken.

Of the 59 Head Start programs participating in the first year study, 35 were located in rural areas and 24 were located in urban areas. At least one program was selected from each of the 10 DHEW Regions with the exception of Region X (Idaho, Washington, Oregon and Alaska). Sixteen of the programs were located in Region IV (North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Kentucky and Tennessee). In terms of their distribution among the four U.S. Census Regions, (North East, North Central, South and West) the sample of Head Start programs matched almost exactly the proportionate distribution of all Head Start programs.

Eleven of the sample programs reported total enrollments of at least 200 children, 18 reported enrollments between 200 and 400 children, 11 between 400 and 1,000, and 15 programs reported enrollments in excess of 1,000 children. 1/

*Non-Head Start Program Sample*

Non-Head Start programs were chosen from the same communities in which the selected Head Start programs were located. Potential study participants were identified through a number of sources. The director of each selected Head Start program was asked to provide names, addresses and telephone numbers of programs in his/her area that provided services to preschool handicapped children. Other resources contacted for the same purposes included State Departments of Education, local school systems, local Public Health Departments, and State and local directors of Easter Seal agencies and the Associations for Retarded Children.

Approximately 180 non-Head Start programs were identified through these sources, and each identified program was contacted to explain the purpose of the proposed study and to solicit their participation. A total of 104 programs initially agreed to participate.

1/ Enrollment data were not provided for four programs.

From this group of programs, one non-Head Start program was selected randomly from each community in which a sample Head Start program was located. However, 14 Head Start programs had no non-Head Start preschool programs in their communities or had no other programs that were willing to participate.[1] Therefore, a final sample of 46 non-Head Start programs was obtained.

Of the 46 non-Head Start programs participating in the study, 24 were located in rural areas and 22 were located in urban areas. Proportionately, then, the non-Head Start program sample was more urban in character than the Head Start program sample, although only by a slight degree (47.8% vs 40.7%, respectively). Non-Head Start programs were also much smaller in terms of total enrollments. This was due to the fact that 36 of the 46 non-Head Start programs primarily or exclusively served handicapped children. Only four non-Head Start programs had enrollments in excess of 100 children and these were preschool programs associated with public school systems. In addition, almost half of the non-Head Start programs were categorical; that is, they served children with one basic type of handicap.

*It is important that these differences between Head Start and non-Head Start programs are noted, because these differences clearly indicate that Head Start is a relatively unique preschool program that has few, if any, counterparts to which it can be directly compared.* This point should be kept in mind when data are presented concerning the non-Head Start study sample.

### *Head Start Handicapped Sample*

The sample of Head Start handicapped children was selected systematically from coded rosters of handicapped enrollees provided to Applied Management Sciences by the Head Start programs. Systematic selection was required to ensure approximately equal representation of the basic handicapping conditions in the study sample.

After potential sample participants were identified from the coded rosters, the Head Start programs were informed of the selections and asked to secure informed, written parental permission to allow children to be included in the study. Parents were overwhelmingly cooperative in this matter, although the final sample had to be modified in a few instances to accommodate parental requests not to have their children participate.

*The limitations of the enrollee sample should be clearly understood. While Head Start programs were randomly chosen, individual children were not. Consequently, inference from the enrollee*

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[1] There were eight communities with no alternative preschool programs serving handicapped children and six communities in which preschool programs were unwilling to participate in the Phase I study.

*sample to the larger universe of handicapped children in Head Start must be approached cautiously. However, there is no reason to suspect that overall representativeness of the enrollee sample, and to that extent the findings and conclusions presented in this study must be assumed to validly reflect current efforts by Head Start to meet the needs of the handicapped.*

The final enrollee sample included 269 children. With the exception of the blind/visually impaired and the deaf/hearing impaired categories (21 and 23 children, respectively), the distribution of handicaps among the study sample was reasonably uniform (Table 1.1). Fifty-nine speech impaired children were also selected, but this reflects the extremely large proportion of all handicaps served by Head Start that involve speech disorders (approximately 50% of all reported handicaps in the 1976-77 Head Start program year).

Instrumentation and Data Collection Procedures

Instrumentation for the study was developed in conjunction with staff from ACYF. All data collection schedules were developed specifically for this study with the exception of one instrument that made use of selected items from the Fifth Annual Survey of Head Start Handicapped Efforts.

In total, 10 different schedules were developed. Exhibit 1.1 summarizes the respondents, purposes, and method of administration for each of these instruments.

All data were collected by a trained staff of 14 field interviewers between April 1, 1977 and June 10, 1977. Interviewers generally operated in teams of two, although sometimes in the case of smaller programs, only one interviewer was utilized. Teams spent from two to five days in each of the 59 communities visited depending on the number of children sampled from the Head Start programs in question.

Data Analysis Procedures

Study data were analyzed through descriptive statistical techniques including simple one-way frequency distributions and contingency analysis.

TABLE 1.1

| Distribution of Head Start Children According to Handicapping Conditions 1/ | |
|---|---|
| Primary Handicapping Condition | % of Total |
| Visually Impaired | 5.6 (N=15) |
| Blind | 2.2 (N=6) |
| Hearing Impaired | 7.8 (N=21) |
| Deaf | 0.7 (N=2) |
| Physical Handicap | 13.8 (N=37) |
| Speech Impaired | 21.9 (N=59) |
| Health or Developmentally Impaired | 11.2 (N=30) |
| Mentally Retarded | 13.0 (N=35) |
| Specific Learning Disability | 11.5 (N=31) |
| Serious Emotional Disturbance | 12.3 (N=33) |
| Total** | 100 (N=269) |

1/ These data are specific to the Phase I study and do not reflect the actual distribution of the types of handicaps served by Head Start nationally.

EXHIBIT 1.1: STUDY INSTRUMENTATION RESPONDENTS, AND COLLECTION PROCEDURES

| Focus | Instrument | Purpose | Respondent/ Data Source | Method |
|---|---|---|---|---|
| Program-Specific Data on Head Start Programs | Primary Data Interview Schedule | Describe enrollment and termination procedures and types of handicapped children enrolled | Head Start Director | Mailed questionnaire or personal interview |
| | Facilities Walk-Through Checklist, Section A | Describe facilities and equipment in the Head Start centers | Head Start Centers | Observation |
| | Secondary Data Instrument | Determine program demographic characteristics | Fifth Annual Survey | Transcribe data |
| | Non-Enrolled Child Interview Schedule | Describe handicapped children not enrolled in the programs | Parents | Telephone or personal interview |
| Child-Specific Data for Sample Handicapped Children | In-Depth Case Study Schedule | Describe services provided to the child | Program staff | Personal interview |
| | Facilities Walk-Through Checklist, Section B | Determine extent of social integration of child in the classroom | Child in classroom setting | Observation |
| | Service Provider Schedule | Describe characteristics of child's service providers and types of services provided | Service providers | Telephone or personal interview |
| | Written Record Review | Analyze child's diagnostic file | Diagnostic file | Questionnaire |
| Program-Specific Data on non-Head Start programs | Alternate Program Schedule | Determine program characteristics and services typically provided to handicapped children | Program Director | Personal interview |
| | Facilities Walk-Through Checklist, Section A | Describe program's facilities and equipment | Program building and classrooms | Observation |

## FINDINGS

Findings of the Phase I study are highlighted below according to nine major areas of investigation:

- Mainstreaming: Context and Process
- Staff Characteristics
- Recruitment and Outreach
- Screening Services
- Diagnostic Services
- Planning and Curricula
- Monitoring Activities
- Auxiliary Service Providers
- Parent Involvement

Within each of these areas of investigation, study findings are presented in a question-and-answer framework. The questions posed are those that guided the conduct of the Phase I research effort. At the conclusion of each answer, page numbers are provided which reference those sections of the Final Report that may provide additional or more detailed information concerning the issue in question.

## MAINSTREAMING: CONTEXT AND PROCESS

*The basic goal of mainstreaming is to provide handicapped children social experiences with their non-handicapped peers. Such an experience is believed to reduce the negative effects of segregated classrooms on the social, emotional, and cognitive development of handicapped children. In brief, a mainstreaming experience is designed to increase a handicapped child's competence in adjusting to and coping with his/her disability in a society whose social and economic institutions are decidedly oriented toward individuals without physical and/or mental impairment.*

*Mainstreaming is the cornerstone on which Project Head Start has based its services to preschool handicapped children. Although it is a widely endorsed practice for structuring the setting in which special children are served, few programs, public or private, have attempted to implement a mainstreaming strategy to the extent to which Head Start has.*

### *WHAT PROPORTION OF THE SAMPLE CHILDREN WERE SERVED IN A MAINSTREAMED SETTING?*

The overwhelming majority of all Head Start children included in the study sample were served in a mainstreamed setting (98.4%). Only four of the children investigated were not mainstreamed because of the severity of their particular disabilities (p. 3.3-3.4).

### *WHAT TYPES OF MAINSTREAMING STRAGEGIES WERE UTILIZED IN HEAD START CLASSES?*

There are several strategies available for mainstreaming handicapped children ranging from complete full time involvement with non-handicapped peers to partial or reverse mainstreaming. Among the 269 children investigated in this study, 92.6 percent were completely mainstreamed for all program activities. Moreover, 54 percent were involved in complete mainstreaming situations in which educational and/or therapeutic services were augmented by specialists who assisted or consulted with classroom teachers (p. 3.2-3.4).

### *DID THE TYPE OF MAINSTREAM SETTING DIFFER DEPENDING ON THE NATURE AND SEVERITY OF A CHILD'S HANDICAP?*

In general, the nature of a child's handicap did not affect the type of their mainstreaming placement. Children with more severe handicaps, however, were more likely to be mainstreamed in situations in which the regular classroom teacher was provided supportive services by other professionals and specialists. Only twenty-three of the 80 severely handicapped children included in this study were placed in mainstream settings in which the classroom teacher was not provided with supportive services from other professionals (p. 3.3-3.6).

*TO WHAT EXTENT WERE HANDICAPPED CHILDREN SOCIALLY INTEGRATED INTO THEIR RESPECTIVE CLASSES?*

More than 66 percent of the sample children were judged to be fully integrated into Head Start classroom activities. Children diagnosed as mentally retarded or emotionally disturbed were less likely to be fully socially integrated than children with other handicaps. Fifty-seven percent of those children with severe or profound disabilities were judged to be socially integrated whereas this was so for 81 percent of those children with mild impairments[1/] (p. 3.7-3.13).

*TO WHAT EXTENT DID THE SOCIAL EXCHANGES OBSERVED AMONG THE SAMPLE OF HANDICAPPED CHILDREN INVOLVE NON-HANDICAPPED PEERS?*

In almost 85 percent of all in-class observations conducted by field staff, the focus child was observed in a group structure that included non-handicapped peers. In only five percent of these observations was the focus child involved in social situations that included only handicapped children (p. 3.12-3.14).

*HAVE HEAD START PROGRAMS ACQUIRED, OR DEVELOPED, THE APPROPRIATE FACILITIES AND MATERIALS TO MEET THE NEEDS OF THEIR HANDICAPPED ENROLLEES?*

Facilities and materials available to Head Start programs to support the mainstreaming of handicapped children are generally adequate for children with mild or moderate impairments. Many of the Head Start programs visited, though, did not have special equipment or materials that would be necessary to provide services to severely handicapped children. This is no doubt a function of the fact that most Head Start centers were not established to specifically serve handicapped children (p. 3.14-3.26).

*HOW DID HEAD START EFFORTS TO MAINSTREAM HANDICAPPED CHILDREN COMPARE WITH EFFORTS TO MAINSTREAM THE HANDICAPPED IN NON-HEAD START PROGRAMS VISITED?*

Only 13 of the 46 non-Head Start programs visited offered handicapped enrollees a mainstreaming experience. It is clear that Head Start remains in the vanguard of efforts to mainstream handicapped preschool children (p. 3.3).

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[1/] Severity of impairment was determined on the basis of judgments rendered by program staff. In order to assure consistency in these judgments, field staff presented severity level criteria cards for each handicapping condition to program staff to guide their assessments.

## STAFF CHARACTERISTICS

*Classroom staffs determine to a considerable extent the quality of the program experiences to which handicapped children are exposed. Therefore, data were collected concerning the formal preparation and in-service training of staffs serving Head Start and non-Head Start children as one set of indicators of the nature of the respective program experiences. It is important to note, though, that the findings of Phase I addressed formal preparation rather than actual classroom experience. Classroom experience issues are addressed in Phase II of the overall study effort.*

### *WHAT ARE THE EDUCATIONAL BACKGROUNDS OF THE STAFFS IN HEAD START AND NON-HEAD START PROGRAMS?*

Approximately 86 percent of Head Start educational/handicapped coordinators and 43 percent of the Head Start classroom teachers were college graduates. Classroom aides were predominantly high school graduates (45%). The predominant degree area for Head Start educational/handicapped coordinators and classroom teachers was early childhood development (39.7% and 29.8%, respectively). Few Head Start staff had degrees in special education (9.9% of the classroom teachers; 14% of the educational/handicapped coordinators).

Non-Head Start staff had twice the proportion of college graduates among classroom teachers relative to Head Start. Forty-four percent of the degrees among non-Head Start staff were in the area of special education and 12 percent were in early childhood development (p. 4.2; 4.7-4.11).

### *TO WHAT EXTENT WERE CLASSROOM TEACHERS IN HEAD START AND NON-HEAD START PROGRAMS CERTIFIED BY STATE EDUCATION AGENCIES IN THE AREA OF SPECIAL EDUCATION?*

Thirty-eight percent of teachers in a typical non-Head Start classroom were certified in special education by State Education Agencies compared to eight percent of the teachers in Head Start. It must be recognized, however, that non-Head Start programs were often associated with public school systems subject to State certification requirements (p. 4.11).

### *TO WHAT EXTENT DID HEAD START STAFF PARTICIPATE IN ACYF's CHILD DEVELOPMENT ASSOCIATE (CDA) CAREER PREPARATION AND CREDENTIALLING PROGRAM?*

Seven percent of the educational/handicapped coordinators, teachers, and aides serving the sample of Head Start children were credentialled CDA's (9 coordinators, 13 teachers, and 2 aides). Another 20 percent, though, were participating in CDA programs but had not yet completed training (p. 4.6).

*WHAT TYPES OF TRAINING WERE PROVIDED TO HEAD START THAT WOULD BETTER PREPARE THEM TO SERVE HANDICAPPED CHILDREN?*

More than 50 percent of the 269 sample children were served by staff who, during 1976-77, had received in-service training in the following areas: understanding the general nature of handicapping conditions (58%), behavior management (55%), and techniques for individualized instruction (51%). To a lesser degree the sample children were served by staff who had received in-service training in the development of learning objectives (49%), strategies for working with parents of handicapped children (45%), strategies to work with the handicaps of particular children in their classes (31%), and the theory and practice of mainstreaming (14%).

In terms of the amount of training Head Start staff received relative to handicapped children, no more than 22 percent of the sample children were served by staff who had received in excess of 15 hours' instruction in any one training topic. Most in-service training provided to staff in the various topic areas was less than 10 hours in duration (p. 4.4-4.6).

*IN WHAT AREAS DID HEAD START STAFF PERCEIVE ADDITIONAL TRAINING NEEDS?*

Head Start staff indicated a perceived need for additional training in areas related to working with children's specific handicaps (77% of all children); the development of individualized instructional techniques (58% of all children); working with parents of handicapped children (51% of all children); and the preparation of individualized learning objectives (45% of all children) (p. 4.7-4.9).

*HOW DOES THE IN-SERVICE TRAINING PROVIDED TO NON-HEAD START STAFF COMPARE TO THAT PROVIDED TO HEAD START STAFF?*

Non-Head Start programs were more likely to provide training in the areas of behavior management, individualized instruction techniques, and the development of individualized learning objectives. Staff in these programs, on the other hand, were less likely than Head Start staff to receive training in the general nature of handicapping conditions or in strategies to work with parents of handicapped children (p. 4.13).

*WHAT AGENCIES/PROFESSIONALS WERE MOST OFTEN INVOLVED IN PROVIDING TRAINING TO HEAD START STAFF?*

In-service training was provided most frequently by Head Start staff personnel. In specific areas such as behavior management and mainstreaming strategies, training was provided by professionals (consultants and private clinicians) outside of Head Start. Training was infrequently provided through Resource Access Projects, public health departments, State Training Offices, or the public schools.

## RECRUITMENT AND OUTREACH

*Unless impairments are obvious or parents are knowledgeable about normal childhood development, handicaps among preschool children are often overlooked or ignored until entry into the public school system. Furthermore, even in the case of obvious impairment, many parents are either too ashamed to seek help or are unaware that help is available for their child.*

*Therefore, a primary concern of the Head Start effort to serve the handicapped is the development of effective outreach and recruitment procedures to ensure that all children who might benefit from and are eligible for Head Start services are provided the opportunity to enroll.*

### *WHAT TYPES OF OUTREACH/RECRUITMENT PROCEDURES DID THE SAMPLE HEAD START PROGRAMS TYPICALLY USE FOR PURPOSES OF ENROLLING HANDICAPPED CHILDREN?*

Almost all of the Head Start programs (51 of 54 programs) indicated the use of outreach acitivities designed specifically to locate and enroll handicapped children. In general, these methods included media campaigns involving local radio and press as well as speaking engagements before civic and church groups (p. 5.3).

### *HOW DID THE SAMPLE OF HANDICAPPED CHILDREN COME TO THE ATTENTION OF THE HEAD START PROGRAMS?*

Twenty-six percent of the sample children were referred to Head Start specifically because of their handicaps. Another 18 percent were enrolled directly as a result of special outreach efforts designed to identify handicapped children or because of parent referral. More than half of the sample children were enrolled through outreach procedures generally utilized by Head Start to recruit their non-handicapped children (e.g., procedures not specifically oriented toward the handicapped) (p. 5.3-5.4).

### *WHAT AGENCIES OR PROFESSIONALS WERE MOST LIKELY TO REFER HANDICAPPED CHILDREN TO HEAD START?*

Of the 76 sample children referred to Head Start, 36 percent were referred by local social service departments or the public schools. Very few children were referred by private practitioners/consultants or from private agencies such as Easter Seals agencies or Crippled Children's Associations (p. 5.5-5.6).

*TO WHAT EXTENT DO HEAD START PROGRAMS ENCOUNTER COMPETITION WITH OTHER AGENCIES IN EFFORTS TO ENROLL HANDICAPPED CHILDREN? WHAT ARE THE REASONS FOR THIS COMPETITION?*

Eleven of the sample programs had actually experienced interagency conflict over the enrollment of handicapped children and another 17 programs indicated that the potential for interagency conflict exists. The agency most often identified as an actual or potential partner to this conflict is the public school system. Fourteen programs also identified private preschool programs as another actual or potential competitor for handicapped enrollees.

The most common reason given for interagency conflict involves disputes arising from programs serving children in the same geographic area. Thirteen programs cited actual or potential disputes over which programs afforded the most appropriate placement, and seven programs cited disputes centered around issues of funding (p. 5.6-5.12).

*WERE HEAD START PROGRAMS ABLE TO ENROLL ALL HANDICAPPED CHILDREN THEY IDENTIFIED?*

Only one-third of the Head Start programs were unable to enroll all of the handicapped children they identified. Of these programs, 11 cited lack of available openings as the reason for non-enrollment. Nine programs did not enroll children because they failed to meet income guidelines. Thirteen programs cited issues related to the severity of handicap as reasons for non-enrollment.

Most children that Head Start programs were not able to enroll were referred for placement in other programs (p. 5.19-5.29)

*DO HEAD START PROGRAMS ESTABLISH CRITERIA OTHER THAN AGE AND FAMILY INCOME TO ESTABLISH A CHILD'S ELIGIBILITY FOR ENROLLMENT?*

Several Head Start programs used criteria other than age and family income to establish enrollment eligibility for handicapped children. Nine programs would only accept children who were ambulatory; eight required children to be toilet trained; nine established minimum functional development criteria; and nine restricted enrollments to selected handicapping conditions (p. 5.13-5.14).

*TO WHAT EXTENT WERE CHILDREN FROM ABOVE INCOME ELIGIBLE FAMILIES REPRESENTED IN THE PHASE I SAMPLE?*

Sixteen programs had no handicapped children who were from above-income-eligible families. In 40 programs, above-income eligible handicapped children represented less than 10 percent of total program enrollments. In three programs above-income eligible handicapped children represented over 10 percent of the total program enrollment (p. 5.13-5.15).

*HOW DO THE RECRUITMENT AND OUTREACH EFFORTS OF NON-HEAD START PROGRAMS COMPARE TO THOSE OF HEAD START PROGRAMS?*

Non-Head Start programs were more likely to secure their enrollees through referrals than were Head Start programs. Thirteen of the 46 non-Head Start programs relied solely on referrals for enrollments. Another five programs obtained their enrollees solely through parent application. Only nine non-Head Start programs relied extensively on outreach and child find activities to identify handicapped children (p. 5.16).

## SCREENING SERVICES

*Screening is the first step in a series of procedures that Head Start programs undertake to identify, evaluate, and serve children with special needs. Screening is conducted for all Head Start enrollees to determine which children are "at risk" and may have potential developmental impairments. Screening, then, is the process by which children who may have potential handicaps or problems are targeted for indepth diagnostic evaluation. However, screening results are not sufficient, in and of themselves, to determine whether a child should be identified as handicapped.*

*HOW MANY OF THE SAMPLE HEAD START CHILDREN RECEIVED COMPLETE SCREENING SERVICES AS OUTLINED IN HEAD START PROGRAM PERFORMANCE STANDARDS AND GUIDELINES?*

Approximately half of the sample children received complete screening in the areas of vision, hearing, physical coordination and development, speech and language, intellectual development and social/emotional development. Another 45 percent of the sample children were given partial screening services. Only 15 children received no screening services or had screening services that were unreported.

Vision and hearing were the areas in which children were most frequently screened (84.4% and 87%, respectively) while fewer children were screened in the areas of intellectual development and social emotional development (70.1% and 68%, respectively)(p. 6.3-6.6).

*HOW SOON AFTER PROGRAM ENTRY DID HEAD START CHILDREN RECEIVE SCREENING SERVICES?*

Of the 269 Head Start children investigated, 67 (25%) received screening services prior to program enrollment. Another 111 (41.2%) received screening services within three months of program entry as specified in program performance guidelines. Screening for the remaining 91 children either was still in process beyond three months of the time of program entry (28%) or was not completed at all (5%) (p. 6.7-6.10).

*WHO WAS RESPONSIBLE FOR CONDUCTING HEAD START SCREENING ACTIVITIES?*

For most screening activities, Head Start programs frequently utilized the services of professionals who were specialists in the relevant screening areas. For example, 74% of all vision screenings were conducted by trained medical personnel. Speech therapists and audiologists were most often involved in screening for speech and hearing difficulties. Head Start staff teachers most often conducted screening in the areas of intellectual development and social emotional development.

Most professionals utilized in the screening process were full-time or part-time Head Start staff. Other major sources of screening assistance included local and state departments of public health and private practitioners/consultants (p. 6.12-6.18).

*HOW WERE HEAD START SCREENING SERVICES FUNDED?*

Regardless of screening area, Head Start screening services were funded by Head Start Basic or Supplemental Grants for approximately 50 percent of the study children. State and public school monies were another major source of funds for screening in the areas of vision, hearing, and speech. However, Head Start staff did not know or did not report the funding source for screening services for up to 33.1 percent of the sample children, depending on the screening areas (p. 6.18).

*HOW EFFECTIVE WERE HEAD START SCREENING ACTIVITIES IN IDENTIFYING ACTUAL DISABILITIES AND IMPAIRMENTS?*

Head Start screening efforts identified potential disabilities in developmental areas corresponding to children's primary handicapping conditions in 93 percent to 70 percent of the sample cases, depending on the particular handicapping condition. Approximately 70 percent of suspected secondary handicaps were also confirmed through further diagnostic evaluation. Speech and language screenings were most effective in identifying impairments while social/emotional screening procedures resulted in the lowest rate of confirmed handicaps (p. 6.20-6.24).

*HOW DO SCREENING PROCEDURES IN NON-HEAD START PROGRAMS COMPARE TO THOSE ESTABLISHED IN HEAD START PROGRAMS?*

Less than half of the non-Head Start programs generally screen enrollees after program entry. Either screening is completed before admission or these programs enroll children who have already been diagnosed as handicapped. These and other data indicate that non-Head Start programs enroll previously diagnosed children more often then do Head Start programs and that Head Start handicapped enrollees generally come into their program with previously undiagnosed disabilities.

For those non-Head Start programs that do conduct screening activities, the professionals and screening techniques are comparable to those utilized by Head Start (p. 6.24-6.27).

## *DIAGNOSTIC SERVICES*

*Upon completion of the screening process, those children identified as potentially "at risk" are referred to appropriately trained professionals for further evaluation. This further evaluation is designed to identify handicapped children from those who are functioning within the range of normalcy or who are only temporarily impaired. This second, more comprehensive, evaluation is termed diagnosis. A child may be considered to have a confirmed handicapping condition only if diagnostic results so indicate.*

*The ideal diagnostic process may be viewed as consisting of three component functions: 1) confirmation; 2) functional assessment; and 3) development of recommendations. A confirmation indicates the nature of the handicap, and a functional assessment specifies the extent of the disability. Finally, recommendations are made for any necessary therapy, medication, specialized services or educational services. Diagnostic recommendations indicate the appropriate program of services to be provided.*

### *DID THE HEAD START CHILDREN IN THE STUDY SAMPLE RECEIVE APPROPRIATE DIAGNOSTIC CONFIRMATION OF THEIR REPORTED HANDICAPPING CONDITIONS?*

Of the 269 sample children, 232 (86.2%) had received appropriate diagnostic confirmation of their primary handicapping condition. Those handicapping conditions most likely to have diagnostic confirmations were visual handicaps (19 of 21), audiological handicaps (22 of 23), physical handicaps (35 of 37), and speech and communication disorders (58 of 59). Handicapping conditions least likely to have appropriate diagnostic confirmation include specific learning disabilities (23 of 31), emotional disturbance (24 of 33), health impairments (24 of 30), and mental retardation (27 of 35).

"Appropriate" diagnostic confirmation refers to confirmation of the primary handicapping condition in the developmental areas outlined in OCD Notice A-30-333-4, "Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start" (p. 7.3-7.9).

### *WERE THERE ANY HANDICAPPING CONDITIONS THAT EVIDENCED PARTICULAR DIAGNOSTIC DIFFICULTIES?*

The diagnostic criteria for specific learning disabilities seemed to be complex and confusing. As a result, children labeled as such were often confirmed as handicapped in a variety of developmental areas. While in part this reflects cases of multiple handicaps, it also strongly suggests that the category of learning disabled is not clear to those responsible for diagnostic classifications. Although intellectual development is the appropriate developmental area in which to confirm a child as learning disabled, the majority of these children were confirmed as handicapped in speech and language (approximately 77%), followed by intellectual development (approximately 42%). Confirmations of handicap were also reported for these children in the areas of physical coordination, hearing and vision. It should be noted that diagnostic difficulties in this area are largely attributable to "state-of-the-art" deficiencies in available diagnostic procedures (p. 7.8).

*WHEN IN THE PROGRAM YEAR WERE DIAGNOSTIC EVALUATIONS COMPLETED?*

Most diagnostic confirmations were completed relatively late in the program year. By the end of October 1976, less than half of the sample children had received appropriate diagnostic confirmation of their primary handicapping condition. By the end of January , 1977, 68 percent of the sample children had received diagnostic confirmations. The belatedness of diagnostic services clearly has implications for the ability of Head Start staff to develop appropriate individual plans of services (p. 7.9).

*WHO PROVIDED DIAGNOSTIC SERVICES TO HEAD START PROGRAMS?*

Diagnostic service providers seemed to be appropriate and qualified personnel. Physicians, speech therapists/audiologists, and psychologists/psychiatrists were the predominant types of diagnostic providers. These providers were most often in private practice or associated with hospitals or clinics. Social service agencies and public school personnel were used infrequently (p. 7.13-7.20).

*HOW WERE DIAGNOSTIC SERVICES FUNDED?*

Head Start funds (Basic Grant and Program Account 26) were the predominant source of payment for diagnostic services. Combined, these two sources of funding paid for well over half of the diagnostic confirmations in intellectual, speech, and social/emotional development. A combination of joint funding arrangements, and EPSDT funds supported most of the confirmations of handicap in the remaining developmental areas. Inkind services, on the other hand, were rarely received (p. 7.21).

*TO WHAT EXTENT DID HEAD START PROGRAMS MAINTAIN DIAGNOSTIC FILES FOR THEIR HANDICAPPED CHILDREN?*

Of the 269 children included in this study, diagnostic files were maintained for 251. The content of these files varied considerably, however. For some children, copies of all test results, lengthy assessments and recommendations, and detailed procedures for service referral and program monitoring were included in the diagnostic file. In other cases, the files contained little to assist program staff in planning or providing services (p. 7.26).

*TO WHAT EXTENT WERE PARENTS INVOLVED IN THE DIAGNOSTIC PROCESS?*

Parents were reported to be extensively involved in the diagnostic process, both as participants and recipients of information and explanations of diagnostic results. Parents of the sample children were informed of diagnostic results in all but six cases. Head Start was actively involved in the explanation of diagnostic results; for approximately 15 percent of the children, Head Start staff alone was responsible for the explanation of these results to parents and in over half the cases both Head Start and the diagnostician explained findings to the parents (p. 7.24).

*WERE THE SAME DIAGNOSTIC PERSONNEL INVOLVED IN ALL THREE COMPONENTS OF THE DIAGNOSTIC PROCESS (CONFIRMATION, FUNCTIONAL ASSESSMENT, RECOMMENDATIONS)?*

The same set of professional diagnosticians that provided confirmations of handicaps also were largely responsible for the development of service recommendations. However, functional assessments were often conducted by a different set of professionals, usually Head Start personnel (p. 7.26-7.36).

*HOW DO NON-HEAD START PROGRAMS APPROACH THE DIAGNOSTIC PROCESS COMPARED TO HEAD START PROGRAMS?*

For those non-Head Start programs that conduct diagnostic activities, there tends to be increased use of interdisciplinary teams and staff teachers in the diagnostic process. In general, though, the approach of non-Head Start programs to diagnosis appears comparable to Head Start (p. 7.38-7.43).

## PLANNING AND CURRICULA

*Once the diagnostic process has been completed and the special needs of each child identified, it is the responsibility of Head Start to ensure that necessary services are provided to each handicapped child. Because each child is a complex and unique individual, the identification of that child's special needs and the procurement of appropriate services should not be a haphazard or mechanical process. Advanced and individualized planning for each child is required if the program is to be responsive to the special needs of its handicapped children. The development of a comprehensive plan of services, the manner of planning and conducting classroom activities, and the type of curriculum used in the classroom all play an important part in the delivery of these services to handicapped children.*

*HOW MANY OF THE SAMPLE CHILDREN HAD INDIVIDUAL PLANS OF SERVICES?*

Head Start staff reported that individual plans of services had been developed for 187 of the 269 sample children (69%). Of these 187 individual plans of services, 153 were written plans (p. 8.2-8.3)

*WHICH SERVICE COMPONENTS (EDUCATION, HEALTH, NUTRITION, PARENT INVOLVEMENT, AND SOCIAL SERVICES) WERE MOST FREQUENTLY INCLUDED IN CHILDREN'S INDIVIDUAL PLANS?*

Of the 141 of the 153 written plans that field staff were able to review, all included plans for educational activities. Thirty-eight percent included health services plans; 18.4 percent had social services plans; 24.8 percent had parent involvement plans; and 14.2 percent included nutritional services plans (p. 8.4).

*WHAT TYPES OF OBJECTIVES WERE DEVELOPED IN CHILDREN'S INDIVIDUAL PLANS OF SERVICES?*

Considering only the educational plan component, long-range objectives were prepared in 81 of 141 written plans reviewed and short-range goals were located in 99. Eighty-five of these plans included procedures for monitoring and evaluation (p. 8.4-8.5).

*TO WHAT EXTENT DID HEAD START PROGRAM STAFF USE DIAGNOSTIC INFORMATION IN DEVELOPING INDIVIDUAL PLANS OF SERVICES?*

Of the 187 children reported to have an individual plan of services (written or otherwise) Head Start staff indicated that diagnostic information was used extensively in 41.7 percent of these plans, used only slightly in another 29.9 percent, and not at all in 26.7 percent. Reasons most often given as to why diagnostic information was not used included unavailability of information to program staff (27 cases); other sources of information were more useful (34 cases); and diagnostic information was provided too late in the program year (18 cases) (p. 8.5-8.10).

*HOW WERE CLASSROOM ACTIVITIES PLANNED FOR THE HANDICAPPED CHILDREN?*

In general, Head Start planned classroom activities for handicapped children in the same way as for their non-handicapped classmates or activities were planned with slight modification to take into account the nature of a child's disability. In very few instances were classroom activities planned which specifically excluded handicapped children. Likewise, there were few activities planned specifically for individual handicapped children that did not involve their non-handicapped peers. Activities involving communication skills were most often individualized for particular handicapped children (p. 8.10-8.13).

*HOW WERE CLASSROOM ACTIVITIES ACTUALLY CONDUCTED FOR HANDICAPPED CHILDREN?*

While few activities were planned specifically for handicapped children, Head Start staff indicated that considerable individualization was undertaken in the manner in which classroom activities were conducted. Regardless of objective area (cognitive skills, communication skills, self-help skills, self-concept development, and gross and fine motor skills) nearly one-third of the sample children had classroom activities individualized to their specific needs and abilities (p. 8.10-8.13).

*WHAT TYPES OF CURRICULA WERE USED BY HEAD START PROGRAMS?*

Of the 269 sample children, staff indicated that a specific written curriculum was used for 214 (80%). Regardless of objective area, most curricula were locally designed. Commercially-available curricula most frequently used included the Peabody series and curricula designed for use with the Learning Accomplishment Profile.

Whether curricula were locally designed or otherwise, performance-based curricula were used exclusively for approximately 30 percent of the sample children, experientially-oriented curricula were used exclusively for 15 percent of the sample children, and a curricula mixture was used for 55 percent of the sample children (p. 8.13-8.16).

*HOW DO THE PLANNING ACTIVITIES OF NON-HEAD START PROGRAMS COMPARE WITH THOSE OF HEAD START PROGRAMS?*

Non-Head Start programs reported extensive use of written plans that emphasized a high degree of individualized instruction. Although many non-Head Start plans addressed areas of service other than educational strategies, it is apparent that Non-Head Start programs are not as comprehensive in their approach to service delivery as Head Start programs are required to be.

Non-Head Start programs were more likely to emphasize performance-based curricula than Head Start programs. However, like Head Start, many non-Head Start programs favored the use of locally designed materials. Of the commercially available materials, non-Head Start programs showed a preference for the Peabody series and the Portage Project curricula (p. 8.16-8.22).

## MONITORING ACTIVITIES

*One of the critical activities related to providing services to handicapped children according to an individualized plan is monitoring. Monitoring can be described as the process by which the services provided to a child are evaluated in terms of the child's response to these services. A child's plan of services can then be modified on the basis of the results of monitoring activities. That is, assessment of a child's progress, accomplished by monitoring, is intended to feed into an evolving plan of services.*

*FOR HOW MANY OF THE SAMPLE HEAD START CHILDREN WERE MONITORING ACTIVITIES CONDUCTED?*

Program staff reported that regular monitoring or progress reports were completed for 263 of the 269 sample children. Furthermore monitoring reports were located by field staff in the files of 220 children (p. 9.2).

*WHAT TYPES OF TECHNIQUES WERE USED TO MONITOR THE PROGRESS OF CHILDREN?*

Unstructured observation was the most often used technique for monitoring children. Teacher or center-designed checklists and parent reports were also used with relative frequency. Assessments that were part of a standard curriculum or based on formal tests were used for approximately a quarter to a third of the sample children (p. 9.2-9.3).

*WHO CONDUCTED MONITORING ACTIVITIES?*

Head Start classroom teachers were most often involved in monitoring activities.

*TO WHAT EXTENT WERE INDIVIDUAL PLANS OF SERVICE MODIFIED AS A RESULT OF MONITORING ACTIVITIES?*

Of the 187 sample children who were reported to have individual plans of services, program staff reported that monitoring resulted in modification in 172 cases (p. 9.5).

*HOW DO THE MONITORING ACTIVITIES OF NON-HEAD START PROGRAMS COMPARE WITH THOSE OF HEAD START?*

All of the non-Head Start programs included in this study indicated that regular monitoring of progress was conducted for all enrollees. Techniques used for monitoring purposes were very similar to those used for Head Start children (p. 9.5)

## AUXILIARY SERVICE PROVIDERS

*To facilitate comprehensive service delivery to handicapped children in a mainstream setting, Head Start often supplements the services of the program staff with services from a wide variety of professionals. These professionals are primarily used to conduct screening and diagnostic procedures, and they also participate in the delivery of health, therapeutic, and/or educational services to Head Start handicapped children.*

*HOW MANY OF THE SAMPLE HEAD START CHILDREN RECEIVED SERVICES FROM SPECIALISTS DURING THE PROGRAM YEAR?*

Of the 269 sample children, 243 (90.3%) received services at least once during the program year from specialists external to Head Start program staff. For 110 children (40.3%), specialists were involved in providing services on a regular and frequent basis; that is, as part of their weekly program schedule (p. 10.2-10.4)

*WHAT TYPES OF SPECIALISTS WERE INVOLVED WITH THE SAMPLE CHILDREN?*

Of those professionals who had only limited contact with the sample children (once or twice during the program year), most were physicians, psychologists, and other medical professionals who were involved in diagnostic activities. Professionals who had more frequent contact with the sample children were more often speech therapists, occupational/physical therapists, social workers, and certified special education professionals (p. 10.2-10.4).

*WHAT TYPES OF SERVICES DID SPECIALISTS PROVIDE TO THE SAMPLE CHILDREN?*

Of the 467 service providers contacted, 54 percent provided diagnostic services, 52 percent provided screening services, 42 percent were involved in parent counseling and training, 39 percent provided staff training specific to the needs of individual children, 24 percent provided therapeutic services, 22 percent were involved with educational services, and 21 percent provided health-related services (p. 10.10-10.16).[1/]

*HOW MANY OF THE SAMPLE CHILDREN WERE SERVED BY HEAD START STAFF WITH SPECIAL EDUCATION TRAINING AND/OR RECEIVED REGULAR (WEEKLY) SERVICES FROM OUTSIDE SPECIALISTS?*

Of the 269 Head Start children, 7.8 percent were served by special education staff and received weekly specialist services; 2.6 percent were served by special education staff but did not receive

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1/ Percentages total more than 100 percent because respondents often provided more than one service.

regular services from other specialists; 33.1 percent were not served by special education staff but did receive regular services from specialists; and 56.1 percent were not served by special education staff and did not receive regular specialist services. For the 80 severely/profoundly impaired children in the sample the proportions were 5 percent, 1.2 percent, 47.5 percent and 46.3 percent, respectively (p. 10.10).

*WHO PAID FOR THE SERVICES OF SPECIALISTS?*

Twenty-six percent of the outside specialists contacted provided their services free of charge to Head Start (in-kind). Thirty percent were compensated entirely by Head Start, 17 percent were paid by the agencies or institutions with which they were affiliated, 7.2 were paid through joint Head Start/other agency funding arrangements, and 14 percent were compensated through other arrangements. Funding arrangements for 4 percent were unknown (p. 10.18).

*WHAT ROLE DID HEAD START TAKE IN COORDINATING THE SERVICES PROVIDED BY SPECIALISTS TO HANDICAPPED CHILDREN?*

Most specialists were sought out by Head Start staff to provide services to specific children. Only in a few cases were services instigated by sources other than Head Start. However, in those instances in which this did occur, services were generally not coordinated with Head Start (p. 10.18).

## PARENT INVOLVEMENT

*The active participation of Head Start parents in all aspects of the program is one of the important cornerstones of the Head Start philosophy. For parents of children with special needs, the assistance and guidance which Head Start offers can be of particular significance. To ensure the continuing provision of appropriate services during and after the child's Head Start experience, parents must be aware of and understand the need and importance of these services. Furthermore, to effectively maximize the beneficial experiences of each child, similar and continuing experiences should be provided in the home as well. Parents are the key to a successful and productive program of services for all children, and especially for those who are handicapped.*

*HOW ACTIVELY INVOLVED IN PROGRAM ACTIVITIES WERE PARENTS OF THE SAMPLE CHILDREN?*

Of the 269 sample children, Head Start staff reported that parents were very active in program activities for 27.1 percent of the children, involved to a moderate degree for 29.4 percent, involved to a minor degree for 30.5 percent, and not involved at all for 12.6 percent (p. 11.2).

*DID THE DEGREE OF PARENTAL INVOLVEMENT VARY AS A FUNCTION OF THE TYPE OR SEVERITY OF A CHILD'S HANDICAP?*

There was little association between parent involvement and the handicapping condition and severity level of the child. Parents of mentally retarded children showed a somewhat higher degree of participation, while parents of blind and visually impaired children tended to have a lower degree of involvement. Parents of children who were mildly impaired tended to participate less; those with moderately disabled children were somewhat more active; parents with children of severe or profound handicapping conditions, as well as the blind, deaf and emotionally disturbed, had average to minor involvement (p. 11.2-11.3).

*IN WHAT TYPES OF HEAD START ACTIVITIES WERE THE PARENTS OF SAMPLE CHILDREN INVOLVED?*

More than half of the parents (66.5%, or 179 cases) were involved in functions with other Head Start parents. This would include meetings and social functions. The next major area in which parents were involved was that of making or donating materials for the classroom. Of the 269 sample children, parents of 132 (49.0%) contributed materials for classroom use. In 108 cases (40.1%) parents provided program transportation.

Parents did not seem to take as active a part in the program activities more directly related to service delivery and planning. The single most frequent manner in which parents were involved in service planning was that of being informed of their child's progress.

In 99 cases, parents were asked to approve their child's individual plan of services. Parents infrequently assisted in the design of the individual plan (29 cases) or in the design of activities (32 cases). However, slightly more than one third of the 187 children with individual plans (37.5%, 70 cases) received instructions from their parents at home using performance-based and/or experience-based lesson plans developed by Head Start staff (p. 11.6-11.11).

*WHAT TYPES OF TRAINING DID PARENTS RECEIVE FROM HEAD START STAFF?*

Training provided to parents by Head Start staff was largely directed at making parents more aware of the nature of their children's specific disabilities (p. 11.10-11.11).

*HOW DOES PARENT INVOLVEMENT IN NON-HEAD START PROGRAMS COMPARE TO PARENT INVOLVEMENT IN HEAD START PROGRAMS?*

There appeared to be little difference between Head Start and non-Head Start programs in the ways in which parents were involved in program activities (p. 11.11-11.13).

## CONCLUSIONS AND RECOMMENDATIONS

There is no question that Head Start programs are exerting considerable effort to comply with the Congressional mandate to seek out and serve handicapped children. In many instances children were encountered who, if not for Head Start, would have remained isolated from their non-handicapped peers and would not have received the assistance they required. Noteworthy examples of Head Start efforts to serve the handicapped included one or more programs that:

- made creative use of "reverse" mainstreaming to provide severely handicapped children the opportunity to interact with their non-handicapped peers in a setting that afforded appropriate supportive services;
- provided instructional services to parents of handicapped children who themselves were handicapped;
- provided technical assistance to other programs involved with handicapped children;
- utilized creative techniques which permitted handicapped children to participate in group lessons/activities with their non-handicapped peers and at the same time receive instruction according to their individual needs;
- established well-equipped instructional centers specifically established for handicapped children;
- closely cooperated with public and private categorical preschool for the handicapped to allow children in these other settings to interact with non-handicapped peers;
- augmented their capacity to provide services to the handicapped by securing in-kind assistance for highly qualified therapists and special educators.

In brief, many Head Start programs are continuing to reach out and serve those children who are too often ignored and forgotten by their respective communities. Furthermore, these children are being served in a comprehensive child development framework that emphasizes mainstreaming and interagency service delivery that is truly unique among programs visited.

### The Evaluator's Perspective

The major purpose of a program evaluation is not, however, simply to applaud efforts that successfully meet a program's objectives. Rather, an evaluation weighs a program's performance against its stated mission and, as a consequence, almost always focuses upon those aspects of a program that are not as effective as they could

be. Based on observed shortcomings, recommendations are then formulated to guide constructive changes and/or innovations which will increase a program's capability to fulfill its particular mission. From the perspective of the evaluator, then, the glass of water is perceived to be partially empty rather than almost full.

There is also another evaluation emphasis throughout this specific study which should be explicated. Head Start emphasizes services to handicapped children within a comprehensive developmental framework. An educational program is but a part of the Head Start service model. Health services, parent/family involvement, social services, and nutritional services are just as important in child development as educational services. For the most part, these other service areas were only superficially considered in this study. Instead, major emphasis was placed upon educational services, particularly special education services. This emphasis was selected principally because of new legislation (Public Law 94-142) which will directly and indirectly affect educational services to all handicapped children regardless of their program placement. Additionally, this emphasis was selected because it is the one service area which is common to Head Start as well as non-Head Start programs. Therefore, for comparative purposes it was the only appropriate service area to address in detail.

Areas for ACYF Action

With the above points in mind, the data from this study have identified several areas in which the services Head Start provides to handicapped children can be improved. There are four major areas in which ACYF can take positive action to effect these improvements. These four areas are as follows:

- diagnostic services provided to handicapped children
- program services provided to handicapped children
- program resources and facilities
- program outreach and recruitment efforts

Recommendations pertaining to each of these issues are presented below. Detailed explanations and justifications of these recommendations may be found in Chapter 12 of the Phase I Final Report.

*Diagnostic Services Provided to Handicapped Children*

The designation of an individual as "handicapped" is not a matter to be taken lightly. To be diagnosed as handicapped may result in stigmatization and the effects of this stigmatization can often be more harmful for the development of an individual than his/her disability. The "handicap" designation creates a set of personal and public expectations that can prohibit the individual from reaching his/her full potential as a functioning member of the community.

This issue is particularly of concern when dealing with the preschool child. This is because many so-called "handicaps" at this age are transitory and, with assistance, will not result in permanent developmental impairment. This is particularly so in the case of mild cognitive, health, or personality dysfunctions. Therefore, any program that is established to serve the preschool handicap child must first ensure that diagnosis is done with extreme care and only to support the delivery of appropriate services.

Although it is the conclusion of this study that Head Start has made significant gains in improving diagnostic services to handicapped children, there still are shortcomings to be addressed. There were instances in which field staff had reservations about the appropriateness of certain diagnoses. In other instances, Head Start teachers were unaware that children in their classes were identified as handicapped. Ear infections were reported as hearing impairments, behavior management problems as emotional disturbance, bilingualism as speech impairment, and unusual body structures as health impairments.

Based on the findings of the Phase I study and the general observations of our field staff, the misuse and abuse of the diagnostic process in Head Start has been identified as largely a function of two factors: 1) failure of some programs to implement existing Head Start standards and criteria in the conduct of the diagnostic process, and 2) pressures to meet the Congressional mandate to ensure that not less than 10 percent of Head Start enrollment opportunities be made available to handicapped children.

SPECIFIC ISSUE:

STUDY DATA REVEALED THAT IN SEVERAL INSTANCES CHILDREN WERE NOT DIAGNOSED AS HANDICAPPED IN ACCORDANCE WITH EXISTING HEAD START STANDARDS AND CRITERIA.

RECOMMENDATION:

ACYF SHOULD TAKE IMMEDIATE STEPS TO ENSURE THAT NO CHILD IS REPORTED AS HANDICAPPED WITHOUT DIAGNOSTIC CONFIRMATION BY APPROPRIATELY CREDENTIALLED PROFESSIONALS.

RECOMMENDATION:

DIAGNOSTIC CRITERIA SHOULD BE MADE MORE STRINGENT IN ALL HANDICAPPING AREAS, PARTICULARLY IN THE AREAS OF LEARNING DISABILITIES AND EMOTIONAL DISTURBANCE. ACYF SHOULD ACCEPT THE LEAD IN ESTABLISHING INTERAGENCY EFFORTS TO DEVELOP DIAGNOSTIC CRITERIA WHICH MIGHT SERVE AS A REFERENCE FOR ALL AGENCIES PROVIDING DIAGNOSTIC SERVICES TO HANDICAPPED CHILDREN.

SPECIFIC ISSUE:

PROGRAM STAFF ADMITTED THAT MISUSE OF THE DIAGNOSTIC PROCESS WAS, IN PART, A FUNCTION OF PRESSURES TO COMPLY WITH THE CONGRESSIONAL MANDATE TO PROVIDE NOT LESS THAN 10 PERCENT OF HEAD START ENROLLMENT OPPORTUNITIES TO HANDICAPPED CHILDREN.

RECOMMENDATION:

ACYF SHOULD DEVELOP GUIDELINES THAT WOULD OUTLINE CREATIVE, CHILD-CENTERED ENROLLMENT STRATEGIES THAT WOULD ALLOW HEAD START PROGRAMS TO FULFILL THEIR MANDATE TO SERVE HANDICAPPED. FOR EXAMPLE, COOPERATIVE ARRANGEMENTS WITH OTHER CATEGORICAL PRESCHOOL PROGRAMS THAT WOULD ALLOW CHILDREN MAINSTREAMING EXPERIENCES MAY BE CONSIDERED.

RECOMMENDATION:

ACYF SHOULD BRING TO THE ATTENTION OF THE APPROPRIATE CONGRESSIONAL COMMITTEE THE NEGATIVE CONSEQUENCES OF THE LEGISLATIVE MANDATE. ACYF SHOULD RECOMMEND TO CONGRESS THAT THE 10 PERCENT QUOTA SHOULD BE CONSIDERED A GUIDELINE RATHER THAN A REQUIREMENT AND THAT ACCOUNT 26 FUNDS SHOULD BE MADE AVAILABLE WHETHER OR NOT A PROGRAM MEETS THIS GUIDELINE.

RECOMMENDATION:

ACYF SHOULD CONSIDER A LONGITUDINAL STUDY OF HANDICAPPED CHILDREN ENROLLED IN HEAD START THAT WOULD HAVE AS ONE OF ITS OBJECTIVES AN ASSESSMENT OF THE VALIDITY OF DIAGNOSTIC RESULTS HEAD START USED TO ASSIGN HANDICAPPED LABELS. IDEALLY, SUCH AN ASSESSMENT SHOULD BE CONDUCTED AFTER CHILDREN ENTER THEIR THIRD YEAR OF PUBLIC SCHOOLING WHEN THE PERMANENCY OF DISABILITIES BECOMES MORE APPARENT.

*Program Services Provided to Handicapped Children*

Data from this study have indicated some Head Start programs are not yet completely prepared to deliver the kind of quality service that handicapped children demand. For example, nearly all the sample children were mainstreamed, but 39 percent were mainstreamed without supportive services. There were several children (10 of 71) with severe handicaps who were considered mainstreamed but some question exists as to whether they were actually benefitting from being mainstreamed because they remained essentially isolated from their non-handicapped peers.

Furthermore, nearly 40 percent of the children investigated were not provided instructional programs guided by a formal (written) individualized plan of services. Among those children who did have plans, many relied on non-directed learning experiences to develop social, cognitive, and motor skills.

Other data indicated that compared to non-Head Start programs, Head Start staff were less prepared academically to serve handicapped children and that this deficit was not being adequately addressed through inservice training.

Finally, and perhaps most critically, functional assessments, so necessary to the development of appropriate plans of services, were not completed for many of the sample children until the program year was well under way.

Based on these findings, ACYF needs to consider steps to upgrade the quality of services Head Start programs provide to handicapped children.

SPECIFIC ISSUE:

FUNCTIONAL ASSESSMENTS NECESSARY FOR THE DEVELOPMENT OF INDIVIDUALIZED PLANS OF SERVICES WERE FREQUENTLY NOT COMPLETED UNTIL LATE IN THE HEAD START PROGRAM YEAR.

RECOMMENDATION:

IN ORDER TO DELIVER SERVICES TO HANDICAPPED CHILDREN IN A TIMELY MANNER, SCREENING ACTIVITIES SHOULD OCCUR PRIOR TO PROGRAM ENTRY INSOFAR AS POSSIBLE, OR AT LEAST IMMEDIATELY FOLLOWING PROGRAM ENTRY. TO FACILITATE THIS PROCESS, ACYF SHOULD MAKE FUNDS AVAILABLE FOR SCREENING ACTIVITIES DURING THE CURRENT PROGRAM YEAR FOR THE UP-COMING YEAR'S RECRUITMENT EFFORTS.

RECOMMENDATION:

THE ORDER AND RELATIVE PRIORITY OF THE COMPONENTS OF THE DIAGNOSTIC PROCESS SHOULD BE CHANGED. SPECIFICALLY, FUNCTIONAL ASSESSMENTS SHOULD OCCUR AS EARLY IN THE PROGRAM AS POSSIBLE. CONFIRMATION OF HANDICAPS MAY, IF NECESSARY, BE CONDUCTED AT A LATER DATE, SINCE THE CONFIRMATION COMPONENT OF THE DIAGNOSTIC PROCESS, BY ITSELF, IS NOT AS CRITICAL TO THE DEVELOPMENT OF SERVICE PLANS. APPROPRIATELY CREDENTIALLED PROFESSIONALS SHOULD BE INVOLVED IN FUNCTIONAL ASSESSMENT PROCEDURES.

SPECIFIC ISSUE:

MANY OF THE HEAD START CHILDREN INCLUDED IN THIS STUDY DID NOT HAVE INDIVIDUAL PLANS OF SERVICES OR HAD PLANS OF SERVICES THAT PROVIDED FOR INCOMPLETE STRATEGIES TO PROMOTE THE DEVELOPMENT OF HANDICAPPED CHILDREN.

RECOMMENDATION:

ACYF MUST TAKE STEPS TO ENSURE THAT HEAD START STAFF DEVELOP COMPREHENSIVE INDIVIDUALIZED SERVICE PLANS FOR THEIR ENROLLEES. ACYF MUST DELINEATE AS CLEARLY AS POSSIBLE THE PROCESS OF INDIVIDUALIZED PLANNING, THE AREAS THESE PLANS MUST ADDRESS, AND THE MODIFICATION OF PLANS AS A FUNCTION OF ONGOING ASSESSMENT.

RECOMMENDATION:

THE EDUCATIONAL SERVICES PLAN FOR HANDICAPPED CHILDREN SHOULD MEET THE REQUIREMENTS OF INDIVIDUAL EDUCATIONAL PLANS (IEP) AS OUTLINED IN PUBLIC LAW 94-142. THIS WOULD GREATLY FACILITATE SERVICE CONTINUITY BETWEEN HEAD START AND THE PUBLIC SCHOOLS.

RECOMMENDATION:

GREATER EMPHASIS SHOULD BE PLACED ON EDUCATIONAL SERVICE PLANS THAT REQUIRE OBJECTIVE-BASED INSTRUCTIONAL STRATEGIES.

SPECIFIC ISSUE:

SEVERAL CHILDREN INCLUDED IN THIS STUDY WERE FOUND TO BE MAINSTREAMED ONLY IN THE BROADEST SENSE OF THE TERM; THAT IS, SOME HANDICAPPED CHILDREN WERE SERVED IN THE COMPANY OF NON-HANDICAPPED PEERS BUT REMAINED SOCIALLY ISOLATED.

RECOMMENDATION:

ACYF SHOULD ESTABLISH TECHNICAL ASSISTANCE EFFORTS TO BETTER PREPARE HEAD START PROGRAM STAFF TO IMPLEMENT VARIOUS MAINSTREAMING OPTIONS THAT COULD BE IMPLEMENTED THAT WOULD BEST MEET THE INDIVIDUAL NEEDS AND ABILITIES OF THE CHILD. IT IS IMPORTANT THAT MAINSTREAMING BE A MEANS TO AN END RATHER THAN AN END IN ITSELF.

SPECIFIC ISSUE:

HEAD START STAFF APPEAR TO LACK FORMAL PREPARATION TO DEAL WITH THE SPECIAL NEEDS OF THE HANDICAPPED AND THIS LACK OF FORMAL PREPARATION IS NOT ADEQUATELY COMPENSATED THROUGH THE UTILIZATION OF OUTSIDE PROFESSIONALS.

RECOMMENDATION:

ACYF SHOULD EXPAND THE EXISTING CHILD DEVELOPMENT ASSOCIATE (CDA) PROGRAM TO INCLUDE THE CREDENTIALING OF STAFF IN SPECIAL EDUCATION SERVICES.

RECOMMENDATION:

ACYF SHOULD PROVIDE FUNDS THROUGH ACCOUNT 26 TO PERMIT HEAD START STAFF SPECIFICALLY TO SECURE THE SERVICES OF OUTSIDE PROFESSIONALS FOR PURPOSES OF PROVIDING DIRECT AND INTENSIVE SERVICES TO HANDICAPPED CHILDREN ENROLLED IN HEAD START.

### *Resources and Facilities*

Another area in which ACYF could improve the Head Start handicapped effort concerns the resources and facilities available to Head Start programs. Study data clearly indicated that many Head Start classrooms are not equipped to serve certain handicapped children, particularly those that are severely handicapped and/or are physically handicapped. This lack of equipment involves not only aspects of the physical plant of Head Start classrooms (e.g., plumbing and sanitary facilities) but also special instructional materials to support educational and therapeutic programs.

Also, during the course of field work activities, Head Start staff personnel often asked for assistance in such areas as the selection of screening instruments, acquisition of staff training

materials to support their handicapped services, and the interpretation of various Head Start program standards and regulations pertaining to handicapped children. In short, ACYF must devote more attention to providing resource support and technical assistance to Head Start programs.

SPECIFIC ISSUE:

HEAD START CLASSROOMS ARE OFTEN NOT EQUIPPED TO MEET THE NEEDS OF SEVERELY HANDICAPPED CHILDREN.

RECOMMENDATION:

ACYF SHOULD MORE AGRESSIVELY PUBLICIZE THE AVAILABILITY OF ACCOUNT 26 FUNDS FOR UPGRADING AND MODIFYING PHYSICAL FACILITIES AND SPECIAL EQUIPMENT NECESSARY TO PROVIDE APPROPRIATE SERVICES TO THE SEVERELY HANDICAPPED.

RECOMMENDATION:

ACYF SHOULD PROVIDE HEAD START PROGRAMS WITH TECHNICAL ASSISTANCE TO IDENTIFY ARCHITECTUAL BARRIERS TO SERVING THE HANDICAPPED AND HOW TO USE AVAILABLE FUNDS TO UPGRADE CLASSROOM FACILITIES.

RECOMMENDATION:

ACYF SHOULD DEVELOP EQUIPMENT AND MATERIALS GUIDELINES FOR HEAD START PROGRAMS SO THAT PROGRAM STAFF CAN BETTER EVALUATE THEIR SPECIFIC EQUIPMENT NEEDS. THESE GUIDELINES SHOULD, WHEN APPROPRIATE, BE DEVELOPED FOR EACH OF THE BASIC HANDICAPPING CONDITIONS SERVED BY HEAD START.

SPECIFIC ISSUE:

HEAD START PERSONNEL, IN SOME PROGRAMS, ARE UNAWARE OR UNSURE OF METHODS AVAILABLE FOR WORKING WITH HANDICAPPED CHILDREN. FURTHER, PROGRAM STAFF ARE UNSURE ABOUT HEAD START PROGRAM REGULATIONS AND STANDARDS THAT APPLY TO EFFORTS TO SERVE HANDICAPPED CHILDREN.

RECOMMENDATION:

EFFORTS SHOULD BE MADE TO PROMOTE THE UTILIZATION OF RESOURCE ACCESS PROJECTS (RAPs) TO STRENGTHEN THE QUALITY OF SERVICES HEAD START PROGRAMS CAN PROVIDE HANDICAPPED CHILDREN. SPECIFICALLY, RAPs SHOULD BE PROVIDED WITH BUDGETS TO CONDUCT TRAINING AND TECHNICAL ASSISTANCE ACTIVITIES THAT HERETOFORE RAPs WERE FORCED TO ARRANGE FROM OTHER SOURCES. IF POSSIBLE, RAPs SHOULD BE ESTABLISHED AT THE STATE LEVEL.

### *Outreach and Recruitment*

Study data indicate that one of the basic differences between the Head Start and non-Head Start programs was that Head Start

programs were more likely to enroll handicapped children through their own screening and outreach efforts rather than through referrals of children previously identified as handicapped by other agencies or professionals. At first glance, this could be considered a strong point of the Head Start handicapped effort because it indicates that Head Start is targeting on children whose disabilities would likely have gone unserved and unrecognized until their entry into the public school system.

However, nearly 60 percent of all the handicapped enrollees in the study sample were identified through normal recruitment and enrollment procedures. Very few of the sample children were recruited as a result of special outreach efforts designed to identify and serve handicapped children. What this indicates is that the majority of the children designated as handicapped came from the population Head Start would probably have served even without the mandate to enroll the handicapped.

SPECIFIC ISSUE:

HEAD START OUTREACH EFFORTS DO NOT APPEAR TO BE VERY EFFECTIVE IN LOCATING HANDICAPPED CHILDREN IN THE COMMUNITY.

RECOMMENDATION:

ACYF SHOULD MAKE ARRANGEMENTS FOR INCREASED TRAINING AND TECHNICAL ASSISTANCE IN RECRUITMENT AND OUTREACH TECHNIQUES DESIGNED TO IDENTIFY CHILDREN WITH POTENTIAL DISABILITIES. IN ADDITION, ACCOUNT 26 FUNDS SHOULD BE MADE AVAILABLE TO SPECIFICALLY SUPPORT THESE OUTREACH ACTIVITIES. THESE FUNDS SHOULD BE PROVIDED AT THE SAME TIME SCREENING FUNDS ARE PROVIDED (SEE p. 31).

RECOMMENDATION:

AT THE NATIONAL, STATE, AND LOCAL LEVELS, HEAD START NEEDS TO UPGRADE PROMOTIONAL EFFORTS TO INFORM NOT ONLY THE GENERAL PUBLIC BUT ALSO OTHER AGENCIES OF THE SERVICES HEAD START CAN PROVIDE TO HANDICAPPED CHILDREN.

SPECIFIC ISSUE:

HEAD START PROGRAMS ARE OFTEN UNAWARE, OR NOT A PART OF, STATE OR LOCAL CHILD FIND AND REFERRAL SYSTEMS.

RECOMMENDATION:

ACYF, PARTICULARLY AT THE REGIONAL LEVEL, SHOULD TAKE ACTION TO ENSURE THAT HEAD START GRANTEES ARE LINKED TO STATE AND/OR BEH-FUNDED CHILD OUTREACH PROJECTS AND OTHER REFERRAL SERVICES OPERATED BY AGENCIES SUCH AS ASSOCIATIONS FOR RETARDED CITIZENS, EASTER SEALS, UNITED CEREBRAL PALSY ASSOCIATION, AND EPSDT CLINICS. AT THE NATIONAL LEVEL, ACYF SHOULD ESTABLISH STRONG INTERAGENCY COORDINATION WITH THE CHILD HEALTH ASSESSMENT PROGRAM (CHAP) TO ENSURE THAT NEW FEDERAL EFFORTS IN THE AREA OF CHILD HEALTH INCLUDE ACYF INPUT.

SPECIFIC ISSUE:

HEAD START PROGRAMS ARE UNSURE OF THEIR RESPONSIBILITIES CONCERNING PUBLIC LAW 94-142

RECOMMENDATION:

ALTHOUGH PL 94-142 PERTAINS TO PROGRAMS OPERATED UNDER THE AUSPICES OF STATE EDUCATION AGENCIES, ACYF SHOULD TAKE STEPS TO FAMILIARIZE HEAD START PROGRAMS WITH THIS LEGISLATION AND TO PUBLICIZE THE SIMILARITIES BETWEEN THE PROVISIONS OF PL 94-142 AND THE HEAD START PERFORMANCE STANDARDS.